GOOD MORNING !

2024 Complete CPT and ICD10
For the Chiropractic Provider

"it is critical to stay abreast of changes in CPT and ICD10 and payer billing guidelines related to coding... maintaining current knowledge is imperative for the long-term survival and safety of a practice."

Our Commitment and Mission - To strengthen and grow the Chiropractic profession by providing education, tools, and support that continually improve the productivity, profitability, and well-being of the alternative health community as a whole.

We are very glad that you have joined us today, and we promise to make giving up your day, a worthwhile experience. This seminar has an emphasis on coding, documentation, and compliance with 2024 updates. Our goal is you will be energized to return to the office and implement new protocols to ensure proper reimbursement!

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Samuel A. Collins & the H.J. Ross Staff
E mail: sam@hjrossnetwork.com
HJ Ross Website and E Mail www.hjrosscompany.com office@hjrosscompany.com
Phone 800 562-3335

2024 Department of Health and Human Services Compliance Program

Documentation, Coding, Billing, Medical Necessity, HIPAA-Privacy

Each practice can undertake reasonable steps to implement compliance measures, depending on the size and resources of that practice. Practices can rely, at least in part, upon standard protocols and current practice procedures to develop an appropriate compliance program for that practice. Many practices already have established the framework of a compliance program without referring to it as such.

The incorporation of compliance measures into a physician's practice should not be at the expense of patient care but instead should augment the ability of the physician's practice to provide quality patient care.

7 Components of an Effective Compliance Program This compliance program guidance for individual and small-group practices

1. Conducting internal monitoring and auditing.
2. Implementing compliance and practice standards.
3. Designating a compliance officer or contact.
4. Conducting appropriate training and education.
5. Responding appropriately to detected offenses and developing corrective action.
6. Developing open lines of communication.
7. Enforcing disciplinary standards through well-publicized guidelines.

A well-designed compliance program can:

• Speed and optimize proper payment of claims;

• Minimize billing mistakes;

• Reduce the chances that an audit will be conducted by HCFA or the OIG; and

• Avoid conflicts with the self-referral and anti-kickback statutes. (fee-splitting)

A self-audit is an audit, examination, review, or other inspection performed by and within a physician's or other healthcare professional's business. Self-audits generally focus on assessing, correcting, and maintaining controls to promote compliance with applicable laws, rules, and regulations. The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), includes periodic internal monitoring and auditing in its list of the seven elements of an effective compliance program.[1]

1 Federal Register Vol. 65, No. 194. (2000, October 5). Office of Inspector General. OIG Compliance Program for Individual and Small Group Physician Practices. Retrieved December 18, 2017, from https://oig.hhs.gov/authorities/docs/physician.pdf

CHIROPRACTIC TOP ENFORCEMENT VIOLATIONS

Here are examples of frequent violations that may result in disciplinary actions. Visit the Board of Chiropractic Examiners (BCE) website (**www.chiro.ca.gov**) and click on the links for Rules and Regulations (**www.chiro.ca.gov/laws_regs/regulations.pdf**) and the Initiative Act (**www.chiro.ca.gov/laws_regs/initiative_act.shtml**) for more information on all possible grounds of discipline.

BEYOND SCOPE OF PRACTICE

- Performing surgical procedures
- Furnishing/prescribing controlled substances
- Claiming to treat/cure cancer

CONVICTION OF A CRIME(S)

- Theft
- Domestic violence
- DUI
- Vandalism

EXCESSIVE TREATMENT

- Treatment beyond what is reasonable/necessary or within the standard of care
- Failure to document necessity (conduct a thorough exam, diagnose the condition, implement a treatment plan, and conduct follow-up exams to assess progress)

FAILURE TO RELEASE PATIENT RECORDS WITHIN 15 DAYS OF REQUEST

- Includes requests from patient, patient attorney, patient representative, insurance company, or BCE representatives

FALSE AND/OR MISLEADING ADVERTISING

- Sensational claims
- No "D.C." after chiropractor's name
- Fraud/misrepresentation

INSURANCE FRAUD

- Double billing
- Billing for service not rendered
- Upcoding
- Excessive treatment

NEGLIGENCE/INCOMPETENCE

- Physical harm to patient
- Failure to exercise appropriate standard of care

PAYMENT FOR REFERRALS

- Discounts
- Cash/gift cards
- Free services

SEXUAL MISCONDUCT

- Erotic behavior
- Inappropriate touching
- Sexual contact or having sexual relations with a patient, client, customer, or employee

UNLICENSED PRACTICE

- Practicing after license expired
- Failing to promptly renew
- Aiding and abetting unlicensed individuals

VIOLATION(S) INVOLVING DRUGS/ALCOHOL

- DUI
- Possession or use of any illicit drugs
- Practicing while impaired
- Prescription medication abuse

BOARD of CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Phone: (916) 263-5355 | Fax: (916) 327-0039
CA Relay Service TT/TDD: (800) 735-2929
Consumer Complaint Toll-Free Hotline: (866) 543-1311
Email: **chiro.info@dca.ca.gov**
"Like" us on **Facebook** and follow us on **Twitter**.

REVISED: JUNE 2018
PDE_18-172

What Triggers Audits?

- High-level E&M codes done routinely 99204/99214, 99205/99215
- Billing E&M daily
- Routine billing of 4 or more services per visit
- Care that appears preventative or supportive
- Extended care for non-complicated conditions
- Patient/Employee making complaints to the insurer

The Gold Standard

- A chiropractor should maintain accurate and complete medical records and documentation of the services they provide.
- A chiropractor also should ensure that the claims they submit for payment are supported by the documentation.
- Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients past medical histories.

The chart notes reflect and can identify the services were performed by what was documented

- E&M services match the level billed based on medical decision making or time
- CMT reflects the diagnosis and regions manipulated
- Therapies identify the service provided by what, where, and time with indication of the purpose or outcome

The Gold Standard

- Another provider can read the notes and clearly identify the service and could perform the service based on what was documented.

Electronic Health Records

- "Services are considered not documented when cloned documentation is identified. Services are denied due to lack of documentation and failure to meet the documentation requirements of BCBS Medical Policy CAM 065."
  - Avoidance of abbreviations (use only standard abbreviations well known to your peers)

- **Cloned Chart Notes:** In accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency, cloned chart notes can result in poor data quality or fraud.
  - **Copy-Pasting:** Copy-pasting, also known as cloning, enables users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians' copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers.

- Templates can be useful tools; however, providers should use caution when using templated language. Blue Cross and Blue Shield discourages templates that provide limited options and/or space for the collection of information, such as checkboxes, predefined answers, choices to be circled etc.
- Templates that just elicit selected information for reimbursement purposes are often not sufficient to demonstrate that coverage and coding requirements have been met.

Do you have to refund?...

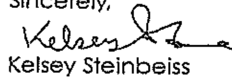
Subscriber Number:
Patient Name:

Dear Billing Department ,

In regards to the request for repayment for claim: the request made to you was a voluntary overpayment reqeust. Because you are an in network provider you do not have to pay back any overpayment if the overpayment was discovered 365 days or more after the claim finalized.

If you have further questions, please contact us at the address listed below or call toll free (800) 824-8839.

Sincerely,



Kelsey Steinbeiss

First of all, I reviewed Ms. Adams's records and I do not show that we have an overpayment resulting in a credit on her account.

Secondly, I do not feel that you have the right to place this burden upon my office by asking us to correct your error, chase down this past patient, and ask her to make an additional payment to our office for a new balance that simply appeared out of nowhere!

I would like to bring to your attention the cases of*: In Federated Mutual Insurance Company vs. Good Samaritan Hospital, (Neb.1974) 214 N.W.2d 493*, where the court held that the insurance company could not recover the mistaken overpayment and determined that "the insurance company is in the best position to know what the policy limits are and must bear the responsibility for their own mistake." As well as, *The City of Hope National Center vs. Western Life Insurance Company, 2 Daily Journal D.A.R. 10728, Decided July 31, 1992,* where the court held that, *in the absence of fraud*, a health care provider is not legally obligated to refund payments it receives from an insurer if the insurer subsequently determines that they were paid in error.

Based on these and other court decisions, I will not be sending your company a refund for $276.00 for the erroneous reimbursement payment you are claiming as due.

Sincerely,
John C. Smith, DC

INSURANCE COMPANY REQUESTING REFUND ON OVERPAYMENT

Note this does not apply to Medicare, Workers' Compensation, Self-Insured Plans, and Managed Care

Date

Blue Shaft Insurance Co.

Re: Sally Adams
Claim # 44-8980
Dates of Service: (dates)

Dear Sirs:

On (date), we received a letter from your company requesting that we refund the amount of $276.00 to Blue Shaft for a payment that was made in error *(beyond policy limits)* back in (date).

First of all, I reviewed Ms. Adams's records and I do not show that we have an overpayment resulting in a credit on her account.

Secondly, I do not feel that you have the right to place this burden upon my office by asking us to correct your error, chase down this past patient, and ask her to make an additional payment to our office for a new balance that simply appeared out of nowhere!

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Sincerely,
John C. Smith, DC

Statute of Limitations of Recoupment

- AZ, CA, WA – 1 Year
- AK, HI, ID NV, OR - None
- UT– 36 Months

Statute of Limitations of Recoupment

- CT – 5 years
- NC, NY – 2 Years
- DC, MA, MD ME, NH, NJ, TN– 18 Months
- DE, PA, RI, VT – No statute
- FL, VA, – 12 months
- GA – 90 days
- SC, TX -180 days
- WV – 1 year
- Illinois - 18 months
- Indiana – 2 years
- Wisconsin – No statute
- Missouri – 12 months
- Iowa – 2 years
- Michigan – No Statute

What Is Insurance?

- Health Insurance?
- Sick Insurance
- Not preventative in design
- It aids in paying for services does not pay in full, in most instances

Variance of Insurance Reimbursement

- Some plans may pay more than several hundred dollars per visit for chiropractic-related services
- Other plans may pay as little as $25-$60 maximum per day
- Some plans have no benefits however, most plans do have some benefits for chiropractic
- Visits may be limited and combined with PT, and Acupuncture
- Deductibles can vary widely – If someone has a $1000 deductible, they are very likely a "cash patient"

Why Insurance? Is it worth it?

Cash Practice

1. Cash
2. Prompt Pay
3. Prepay

Insurance Practice

1. Standard
2. PPO
3. HMO (EPO)
4. HSA or FSA
5. Automobile (Personal Injury)
6. Workers' Compensation
7. Veterans Administration
8. Medicaid (Medi-Cal)
9. Medicare

92% of Americans have some health insurance but do not mean they are all good insurance

PPO Discounts

- In network
- Out of Network

Insurance

- Insurance aids in payment and rarely covers 100%
- New patients
- Someone may be more apt to try Chiropractic
- You are not required to bill insurance and may simply provide a receipt or "superbill" for patient to submit to insurance if they have it

Data suggest that Americans are **increasingly willing to pay out-of-pocket** for acupuncture, chiropractic, or massage care that isn't covered by health insurance, reports a new study led by the National Center for Complementary and Integrative Health.

American Physical Therapy Association

- **Higher copayments decreased the likelihood of a patient seeing a physical therapist as first provider.** Patients with a copayment over $30 were 29% less likely to see a physical therapist first than were patients with no copayment. This association was not evident for chiropractic.
- "*I know many of us look at the way DCs have branded themselves in the last few decades and feel a twinge of resentment-why can't that be us?*

Cash and Prompt Pay Discounts

- Waiving
- Hardships

Cash and Prompt Pay

Waiving co-payment, co-insurance and deductible. If a physician's office routinely fails to collect the patient's portion of the care, it is considered a violation of both the Anti-Kickback Statute (AKS) AND the False Claims Act. OIG and the Department of Justice recognize that there are cases of financial hardship and make allowances for those unable to pay. They also recognize when a physician makes a reasonable effort to collect from a patient, but does not receive payment. It is the *routine waiver* of the patient responsibility that can cause serious consequences.

A reasonable "discount" for payment at the time of service, or so called "bookkeeping" discount can be within legal bounds. What's key, however, is how the provider sets discount policies.

Helping patients afford care is the compassionate and right thing to do. But offering a cash rate that is substantially lower than the insurance rate is and may be considered fraud.

What is reasonable? **OIG Advisory Opinion No. 08-03 provides protocol for such discounts.**

Following the broad guidance of the OIG, in a recent opinion, they O.K.'d a 5%-15% "Prompt Payment" discount for a particular hospital

Think defensible, what is the actual bookkeeping savings for not doing the administrative and clerical work associated with billing insurance not to mention the waiting period for payment and you are on the right track.

Charging 5-15% more for identical services where the additional burden of billing and collection is eliminated is certainly reasonable. However charging significantly more than the rate charged for a pay in full at the time of service patient would not be considered fair or reasonable. Certainly there is a cost to the added work but not double the cost of the actual chiropractic service.

Dear Sir or Madam:

As part of UnitedHealthcare's role to monitor the appropriateness of paid medical claims and verify adherence to standard billing procedures, we request your assistance with a compliance review for your patients, who are UnitedHealthcare members.

Please assist us in this review by completing the Attestation of Proof of Member Responsibility (Attestation)[1] and submitting proof that our members paid their copays, coinsurance, and/or deductible for each of the claims listed on the attached Attestation. Proof of payment includes, but is not limited to, credit card/check receipts, patient ledgers and/or payment contracts. If the member received a hardship waiver, please provide the supporting documentation.

> If our members have not yet paid their copays, coinsurance, and/or deductible, please assist us by completing the Attestation and providing documentation of your attempt(s) to collect each member's responsibility or documentation of your waiver of each member's responsibility, including but not limited to hardship waivers.

Please submit the requested information in **PDF format via a secured electronic format,** along with a copy of this letter and an executed copy of the Attestation within 30 days of the date of this letter to:

Rhina Bustamante
Fax: 844-738-8850
Email: rhina.bustamante@uhc.com

Thank you for your cooperation and assistance. Please contact us at 763-361-0559 if you have any questions or require additional information.

09/20/2023

Sent via fax:

UHC SIU Case Number:

Re: Request for Records

Dear Sir or Madam

As part of UnitedHealthcare's role to monitor the appropriateness of paid medical claims and verify adherence to standard billing procedures, we request your assistance with a compliance review for your patients, who are UnitedHealthcare members.

Please assist us in this review by completing the Attestation of Proof of Member Responsibility (Attestation)[1] and submitting proof that our members paid their copays, coinsurance, and/or deductible for each of the claims listed on the attached Attestation. Proof of payment includes, but is not limited to, credit card/check receipts, patient ledgers and/or payment contracts. If the member received a hardship waiver, please provide the supporting documentation.

> If our members have not yet paid their copays, coinsurance, and/or deductible, please assist us by completing the Attestation and providing documentation of your attempt(s) to collect each member's responsibility or documentation of your waiver of each member's responsibility, including but not limited to hardship waivers.

Please submit the requested information in PDF **format via a secured electronic format,** along with a copy of this letter and an executed copy of the Attestation within 30 days of the date of this letter to:

Washington Administrative Code

- WAC 246-808-545
- **Improper billing practices.**
  - The following acts shall constitute grounds for which disciplinary action may be taken:
  - (1) Rebating or offering to rebate to an insured any payment to the licensee by the third-party payor of the insured for services or treatments rendered under the insured's policy.
  - (2) Submitting to any third-party payor a claim for a service or treatment at a greater or an inflated fee or charge than the usual fee the licensee charges for that service or treatment when rendered without third-party reimbursement.

Oregon Revised Statutes 742.525

- **(1)** Except as provided in subsection (2) of this section, a provider shall charge a person who receives personal injury protection benefits or that person's insurer the lesser of:

(a) An amount that does not exceed the amount the provider charges the general public; or

(b) An amount that does not exceed the fee schedules for medical services published pursuant to ORS 656.248 (Medical service fee schedules) for expenses of medical, hospital, dental, surgical and prosthetic services.

Minnesota Cash Discounts

72A.20 METHODS, ACTS, AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE

Subd. 39.**Discounted payments by health care providers; effect on use of usual and customary payments.**

An insurer, including, but not limited to, a health plan company as defined in section 62Q.01, subdivision 4; a reparation obligor as defined in section 65B.43, subdivision 9; and a workers' compensation insurer shall not consider in determining a health care provider's usual and customary payment, standard payment, or allowable payment used as a basis for determining the provider's payment by the insurer, the following discounted payment situations:

(1) care provided to relatives of the provider;

(2) care for which a discount or free care is given in hardship situations; and

(3) care for which a discount is given in exchange for cash payment.

NY Office of General Counsel

- **Question Presented:**
- If a chiropractor were to charge a lower fee for services to "non-insurance" patients—that is, patients without insurance or whose contractual benefits under an insurance policy have been exhausted—than to patients whose cost of services is covered by insurance, could the chiropractor's conduct alone constitute insurance fraud?
- **Conclusion:**
- No. If a chiropractor charges a lower fee to non-insurance patients who pay cash, that activity would not constitute insurance fraud, because neither the chiropractor nor the insured would submit any claim for services to an insurer, self-insurer, purported insurer, or any agent thereof. However, if a chiropractor submits a claim to an insurer for an insured patient, or issues a bill to an insured patient for services knowing that the bill will be presented to the insurer, then the chiropractor would be wise to fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee.

Business and Professions Code 657.

(a) The Legislature finds and declares all of the following:
(1) Californians spend more than one hundred billion dollars ($100,000,000,000) annually on health care.
(2) In 1994, an estimated 6.6 million of California's 32 million residents did not have any health insurance and were ineligible for Medi-Cal.
(3) Many of California's uninsured cannot afford basic, preventative health care resulting in these residents relying on emergency rooms for urgent health care, thus driving up health care costs.
(4) Health care should be affordable and accessible to all Californians.
(5) The public interest dictates that uninsured Californians have access to basic, preventative health care at affordable prices.
(b) To encourage the prompt payment of health or medical care claims, health care providers are hereby expressly authorized to grant discounts in health or medical care claims when payment is made promptly within time limits prescribed by the health care providers or institutions rendering the service or treatment.
(c) Notwithstanding any provision in any health care service plan contract or insurance contract to the contrary, health care providers are hereby expressly authorized to grant discounts for health or medical care provided to any patient the health care provider has reasonable cause to believe is not eligible for, or is not entitled to, insurance reimbursement, coverage under the Medi-Cal program, or coverage by a health care service plan for the health or medical care provided. Any discounted fee granted pursuant to this section shall not be deemed to be the health care provider's usual, customary, or reasonable fee for any other purposes, including, but not limited to, any health care service plan contract or insurance contract.
(d) "Health care provider," as used in this section, means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

Packages and Plans

"Joint Model"

- Fee for service (visits) not time
- Refund policy for unused
- No expiration

Texas SECTION 75.5. Prepaid Treatment Plans

(a) A licensee may accept prepayment for services planned but not yet delivered, but must provide the following:

(1) The plan must be cancellable by either party at any time for any reason without penalty of any kind to the patient.

(2) Upon cancellation of the plan the patient shall receive a complete refund of all fees paid on a pro rata basis of the number of treatments provided compared to total treatments contracted.

(3) The plan must provide for a limited, defined number of visits.

(4) The patient's file must contain the proposed treatment plan, including enumeration of all aspects of evaluation, management, and treatment planned to therapeutically benefit the patient relative to the condition determined to be present and necessitating treatment.

(A) The patient's financial file must contain documents outlining any necessary procedures for refunding unused payment amounts in the event that either the patient or the doctor discharge the other's services or therapeutic association.

(B) The treatment plan in such cases where prepayment is contracted must contain beginning and ending dates and a breakdown of the proposed treatment frequency.

(5) A contract for services and consent of treatment document must be maintained in the patient's file that specifies the condition for which the treatment plan is formulated.

(6) If nutritional products or other hard goods including braces, supports, or patient aids are to be used during the proposed treatment plan, the patient documents must state whether these items are included in the gross treatment costs or if they constitute a separate and distinct service or fee.

(b) This rule does not create any exemptions from any requirements applicable under the Texas Insurance Code.

Source Note: The provisions of this §75.5 adopted to be effective January 29, 2015, 40 TexReg 379; transferred effective November 1, 2018, as published in the Texas Register October 19, 2018, 43 TexReg 6963

Florida Prepay Plans

- Florida Statute 460.411
- Funds must be in a separate designated account from $501 and not more than $1500
- Advances for costs and expenses of examination or treatment is to be held in trust and must be applied only to that purpose.

- **Montana** also requires monies to be put aside in an escrow account

Georgia Rule 100-7-.08 Contractual Pre-Payments for Services

1. It is considered unprofessional conduct for any chiropractor to enter into a financial contract which obligates a patient for care or payment for care using coercion, duress, fraud, overreaching diagnosis, harassment, intimidation or undue influence

a) Any services provided prior to the signing of the contract must not be included in the contract.

b) The patient must be given a permanent copy of the signed contact; and the contract must provide a clearly defined refund policy typed in not less than 12-point font. An initial line must be next to the refund policy and must be initialed by the patient.

c) The contract must contain the statement "There is insufficient evidence to suggest that not receiving chiropractic care will lead to death, paralysis, disability or permanent harm." Said statement must be typed in not less than 12 point font

2. Any chiropractor who enters into a pre-payment financial contract with a patient must allow the patient 48 hours to sign and return the contract. During this 48-hour evaluation period from the time when a copy of the written contract is provided to the patient; no content of the contract can be changed.

3. Any chiropractor who enters into a pre-paid financial contract with a patient shall determine and record the patient's clinical objective which the pre-paid care is designed to achieve and provide the patient with a copy of this objective.

NY Office of General Counsel

- **Question Presented:**
- What are the parameters under which a chiropractor or chiropractic group practice may contract with patients to provided "unlimited chiropractic care for a fixed fee"?
- **Conclusion:**
- A chiropractor or chiropractic group practice **may not**, for a fixed fee, agree to provide unlimited services, the need for which are occasioned by the happening of a fortuitous event. The chiropractor could, however, charge a pre-set membership fee and then offer a prearranged discount to members for each service that is dependent upon the happening of a fortuitous event, provided that the discounted fee covers the actual cost of the service rendered (i.e., labor, material and reasonable overhead)

NY Office of General Counsel

- **RE: Chiropractic Packages**
- **Question Presented:**
- May a doctor of chiropractic offer a discounted package of treatments in New York?
- **Conclusion:**
- So long as any insurer is not deceived, such packages would not be contrary to the New York Insurance Law (McKinney 2000 and 2005 Supplement).
- Unless a health care professional submits false or misleading information to an insurer concerning his or her charges, which knowing submission might be health insurance fraud, the Insurance Department does not regulate how such a professional charges his or her patients.
- However, if a chiropractor submits a claim to an insurer for an insured patient, or issues a bill to an insured patient for services knowing that the bill will be presented to the insurer, then the chiropractor would be wise to fully disclose to the insurer that it charges non-insurance patients who pay cash a lower fee.

Discount Medical Plans

- Discount medical plans are NOT insurance, a health insurance policy, Medicare prescription drug plan or qualified health plan under the Affordable Care Act. This plan (The Plan) provides discounts only on chiropractic services offered by providers who have agreed to participate in The Plan. The range of discounts for medical or ancillary services offered under The Plan

Discount Medical Programs (CHUSA)

Provider

- **No** joining or credentialing **fees**.
- Offer affordable "in-network" fees to cash, underinsured and out of network patients.
- Offer Medicare & Federally insured patients legal discounts on non-covered services.
- Maintain UCR charges and reimbursements when coverage is available.
- Set and **accept discounts you choose**; discounts NOT dictated by a network

Patient

- No claims, forms or limits on the number of visits
- Memberships of **$39.00 is for the year and covers legal dependents**
- Network discounts **keep care affordable for the entire family**

	RVU							RVU
CMT			Acupuncture				E&M	
98940	0.82		**97810**	1.15			**99202**	2.17
98941	1.18		**97811**	0.85			**99203**	3.35
98942	1.52		**97813**	1.36			**99204**	5.02
98943	0.77		**97814**	1.10			**99205**	6.62
							99211	0.70
Physical Medicine			Dry Needle				**99212**	1.70
97010	0.19		**20560**	0.77			**99213**	2.73
97012	0.42		**20561**	1.11			**99214**	3.85
97014	0.37						**92215**	5.42
G0283	0.35							
97016	0.17		Trigger Point Injection					
97018	0.51		**20552**	1.58			Prolonged Services	
97022	0.22		**20553**	1.82			**99358**	2.65
97024	0.20						**99359**	1.13
97026	0.25		Therapeutic Injection				**99417**	0.92
97028	0.43		**96372**	0.43			**G2212**	0.96
97032	0.58							
97033	0.42						Preventative Medicine	
97034	0.42						**99401**	1.15
97035	1.05						**99402**	1.87
97036	1.04						**99403**	2.57
97039	0.00						**99404**	3.28
97110	0.88							
97112	1.01						X-ray	
97113	1.10						**72040**	1.19
97116	0.88						**72050**	1.61
97124	0.91						**72052**	1.88
97139	0.00						**72070**	0.99
97140	0.81						**72072**	1.19
97150	0.54						**72074**	1.34
97530	1.10						**72082**	2.11
97533	1.87						**72100**	1.20
97535	0.98						**72110**	1.56
97537	0.95						**72114**	1.84
97542	0.95						**72120**	1.22
97545	0.00							
97546	0.00		Interprofessional Telephhone				Telephone & Online	
97750	1.02		**99446**	0.53			**99441**	1.69
97755	1.15		**99447**	1.08			**99442**	2.72
97760	1.43		**99448**	1.60			**99443**	3.85
97761	1.25		**99449**	2.13				
97763	1.57						**99421**	0.45
97799	0.00						**99422**	0.88
0552T	0.00						**99423**	1.40

Every code has a relative value meaning a comparison from one to the other. For example, if a code is valued at 0.75 and another code is valued at 1.0 then the codes would be 25% different

For example, the RVU for 98940 is 0.82 and for 98941 is 1.18

Meaning the value or charge between them would be about 36%

If you know the fee of one code, you can then establish the fees for any other code based on that code with the other's relative value

For example, if you charge $60 for 98940 and have established that is the fair and reasonable fee you can then do every other code based on that fee

$60.00 / 0.82 = 73.17 98940

73.17 x 1.18 = $86.34 98941

73.17 x 3.35 = $$245.12 99203

73.17 x 0.88 = $64.38 97110

Take the value of the service and divide it by its RVU; that number becomes your conversion factor and multiply it by any other code RVU for the rate of that code based on the price of your primary service.

This is how plans determine fees (note ASH et al do not) including Medicare, WC, PI, non-PPO plans et al

You will often find codes way below what is reasonable based on what a plan allows.

Tell me what they allow for one code, and you can figure out what they allow by RVU

NEW PATIENT

A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15-minutes must be met or exceeded.

99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

ESTABLISHED PATIENT

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.

99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 -minutes must be met or exceeded.

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

99202-99215 Code Selection

- Code selection levels are now based on:

– Total time

Spent by the provider on the day of visit face-to-face and non-face-to-face

Or

– Level of Medical Decision Making (MDM)

Severity and complexity of presenting problem

Four types of MDM are recognized: straightforward, low, moderate, and high

Time now represents total provider time spent on date of service, including:

- Physician or other qualified health care professional time includes the following activities, when performed:
- **Preparing to see the patient (eg, review of tests)**
- **Obtaining and/or reviewing separately obtained history**
- **Performing a medically appropriate examination and/or evaluation**
- **Counseling and educating the patient/family/caregiver**
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- **Documenting clinical information in the electronic or other health record**
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

What Time Does Not Count

- Time spent on activities normally performed by clinical staff
- Time spent on separately reportable services
  - X-rays
  - Treatment
  - Travel

MEDICAL REVIEW WHEN PRACTITIONERS USE TIME TO SELECT VISIT LEVEL

- Reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit

Medical Decision Making

Includes 4 levels

- ❖Straightforward
- ❖Low
- ❖Moderate
- ❖High

A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

New Patient

- **99202** Meet or exceed15 min
- **99203** 30 minutes
- **99204** 45 minutes
- **99205** 60 minutes

Medical Decision Making *

- **99202** 1 self limited or minor problem
- **99203** 2 or more / acute injury
- **99204** Acute complicated injury
- **99205** Threat to life or bodily function

Level of Medical Decision Making (MDM)

Revisions effective January 1, 2023 are noted in red text

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low	**Low**
	• **2** or more self-limited or minor problems;
	or
	• **1** stable chronic illness;
	or
	• **1** acute, uncomplicated illness or injury
	or
	• 1 stable acute illness;
	or
	• acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(Must meet the requirements of at least 1 of the 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • review of the result(s) of each unique test*;
		  • ordering of each unique test*
		or
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
			Low risk of morbidity from additional diagnostic testing or treatment

Moderate	**Moderate**
	• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• **2** or more stable chronic illnesses;
	or
	• **1** undiagnosed new problem with uncertain prognosis;
	or
	• **1** acute illness with systemic symptoms;
	or
	• **1** acute complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	**High**
	• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• **1** acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• **Any combination of 3 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

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DENIAL OF E/M CODE
ON THE SAME DAY AS CMT

Date

Double Standards Insurance Company
P. 0. Box 1000
Any City, CA 90000

Re:
Dates of Service:

Attention Claims Review:

This letter is in response to your denial of Evaluation and Management services performed on (date) and (date). Your reason for the denial of these charges is "*this procedure is already included in the Chiropractic Manipulation Treatment procedure billed on the same day.*"

It is reported in the CPT manual (2024 Professional Edition page 873) that the CMT procedure includes a pre- and post-manipulation patient assessment, however, the evaluation and management service performed on (date) was not routine, the evaluation and management service provided was a separately identifiable evaluation and management service, above and beyond the usual pre-service and post-service work associated with the manipulation procedure.

This separate and distinct nature of the exam was indicated on the billing 1500 claim form with the evaluation and management code having modifier 25.

A detailed and separate examination was necessary and beyond the scope of the pre-manipulation assessment. A copy of the actual examination is enclosed so you may see that the evaluation & management service of 99203 was significantly separate and distinct from the treatment provided on the same day.

Since this was indicated to you on the claim by adding modifier -25, I feel your denial is unreasonable and, accordingly, expect reimbursement for these unfairly denied services, along with interest now due, within 10 days of your receipt of this letter.

If we continue to receive your blanket denials whenever Evaluation and management services are properly reported and billed. In that case, I will notify your insured of your tactics and assist in filing for assistance with the Department of Insurance.

My patient and I await your response.

Sincerely,

John C. Smith, DC.

Medicare Add-On

- Code G2211 describes "visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition." In short, G2211 is for evaluation and management (E/M) visits that are part of an ongoing, longitudinal care relationship. It is an add-on code that can be listed separately in addition to office/outpatient E/M visits for new or established patients (i.e. codes 99202-99215).

Prolonged E&M Services

- 99417 Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

- Eligible for separate reimbursement when billed in addition to CPT new/established level 5 Evaluation and Management codes 99205/99215 for office or other outpatient E/M services. The level 5 office or other outpatient E/M code must be selected using only time as the basis of selection and after the total time has been exceeded. (Anthem C-08011 Commercial Reimbursement Policy)

CMS

- **G2212** Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services)
- (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)

Review of Records

- **99358** Prolonged evaluation and management service before and/or after direct patient care, first hour *(30-60 minutes)*
- **99359** each additional 30 minutes (List separately in addition to code for prolonged services)
- Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.
- Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.
- Do not use on the same date as an E&M as the record review time would be counted towards the E&M service

Telemedicine

- Here are the temporary provisions **extended until the end of December, 2024.**
- Expansion which allows telehealth services be provided in any site in the United States where the beneficiary is located, including the patient's home
- Qualified occupational therapist, qualified physical therapists, qualified speech language pathologist, and qualified audiologists may continue to be telehealth providers
- Continued coverage and payment of services included on the Medicare telehealth services list as of March 15, 2020 until December 31, 2024

Telemedicine Definition

- The provider uses an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.

Patient Location

- Proper Licensure: Make sure you are licensed both in the state where you are located, and in the state where your telemedicine patient is located. If your patient is in another state, and you aren't licensed there, check to see about licensing reciprocity. Many states have been extending reciprocity to help address the COVID-19 crisis.
- The key is to make sure you have licenses required in your area to practice telemedicine.

Telemedicine Billing

- Most likely and appropriate coding for interactive audio-video are E&M codes
- Some therapies are allowed
- Place of service 02 location other than patient home or 10 patient home
- Modifier 95 on the E&M Service

Place of service for these codes is 02 or 10

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1		10		99214	95					NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. Rsvd for NUCC Use

95 Modifier

Modifier 95 means: "synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system."

Online Digital Evaluation and Management Services

- **99421** Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes
- **99422** 11—20 minutes
- **99423** 21 or more minutes

- These are patient-initiated E/M services for the assessment and management of the patient. These are not intended for the no evaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M.

- On-line communication (email essentially but through a secure portal as part of EHR)

- If the patient had an E/M service within the last seven days, these codes may not be used for that problem.

- If the inquiry is about a new problem these codes may be billed. Do not use if the online inquiry addresses and issue that was part of an E/M or service in the past 7 days

- Billing is cumulative for a 7-day period and not billed for each interaction

Telephone Calls

- **99441** 5-10 minutes of medical discussion
- **99442** 11-20 minutes of medical discussion
- **99443** 21-30 minutes of medical discussion

- The call must be initiated by the established client or their parent/guardian if they're a minor.
- The length of the phone call must be documented, as well as the nature of the service and other pertinent information.
- The call can't be related to an E/M service you performed and reported within the last 7 days

- Unfortunately, you can satisfy every billing requirement and still not be reimbursed by the insurance company for client calls, since these codes are often not covered. That's why it's important to check the contract to see if these codes are covered and have a policy in place to ensure you're compensated for your time if they're not.
- The best place to do this is on the Consent for Services form you have your client's sign. Make part of this form your out-of-session contact policy, stating that clients will be liable for all charges not covered by insurance. Naturally, this will exclude Qualified Medicare Beneficiaries and some Medicaid clients, who can't be billed for anything, but it will cover your bases with all other clients.

CMS LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022-

99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est

97110	Therapeutic exercises	Available up Through December 31, 2023
97112	Neuromuscular reeducation	Available up Through December 31, 2023
97116	Gait training therapy	Available up Through December 31, 2023
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97535	Self care mngment training	Available up Through December 31, 2023
97750	Physical performance test	Available up Through December 31, 2023
97755	Assistive technology assess	Available up Through December 31, 2023
97760	Orthotic mgmt&traing 1st enc	Available up Through December 31, 2023
97761	Prosthetic traing 1st enc	Available up Through December 31, 2023

Eligibility Prior Authorization Claims and Payments Referrals Our network Resources Sign In

- Chiropractic Therapy
- Electronic Visits
- Home Health and Hospice Telehealth Services
- Physical Health, Occupational and Speech Therapy
- Remote Patient Monitoring
- Telehealth
- Telehealth State Provision Exceptions
- Virtual Check-Ins

Chiropractic Therapy

Last update: May 13, 2021, 11:02 a.m. CT

UnitedHealthcare will temporarily reimburse telehealth services submitted by chiropractors when provided by qualified health care professionals and rendered using interactive audio-video technology for Medicaid and Individual and fully insured Group Market health plan members. Medicare Advantage coverage limitations still apply, as well state laws and regulations. Benefits will be processed in accordance with the member's plan.

Reimbursable codes are limited to the specific set of codes listed here. UnitedHealthcare will reimburse eligible codes on a CMS 1500 form using the place of service that would have been reported had the services been furnished in person along with a 95 modifier, or on a UB04 form with applicable revenue codes.

Originating Site Expansion

UnitedHealthcare is continuing its expansion of telehealth access, including temporarily waiving the Centers for Medicare & Medicaid Services (CMS) originating site requirements.

Benefit Impact

Note: Member's benefits may vary according to benefit design. Member benefit language should be reviewed before applying the terms of this policy.

- Telehealth visits and services are applicable to health plan coverage limitations.
- Telehealth visits and services must be eligible for separate payment when performed face-to-face
- Deductibles and co-payments are the same as in-person visits, unless otherwise stated.
- Unless otherwise stated, telehealth services are reimbursed at the same rate as they would when performed in an office setting
- Telehealth visits and services are subject to the same utilization management policies and payment audit programs as with in-person (face-to-face) visits

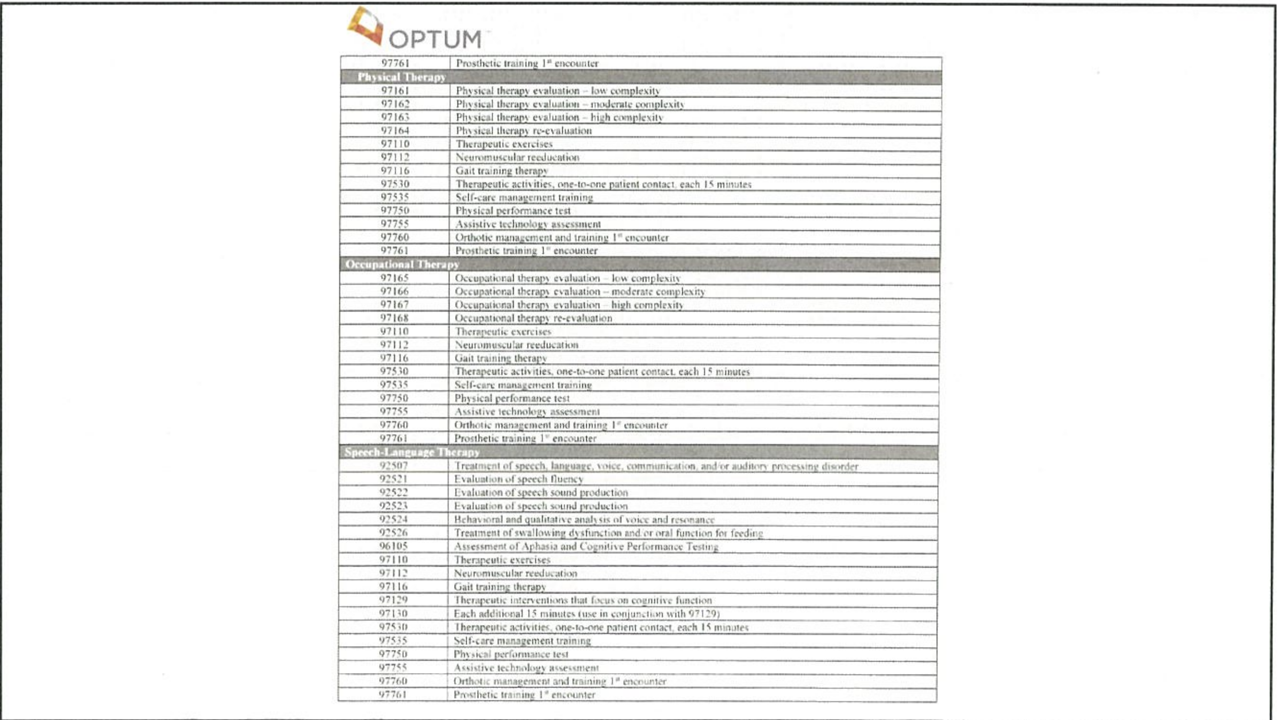
Definitions

Term	Description
Distant Site	The location of a physician or other qualified health care professional at the time the service being furnished via a telecommunications system occurs
Originating Site	The location of a patient at the time the service being furnished via a telecommunications system occurs
Qualified Health Care Professional	An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service
Store-and-Forward Technology	Technologies that collect images and data to be transmitted and interpreted later
Telehealth	Telehealth services are live, interactive audio and visual transmissions of a clinician-patient encounter from one site to another using telecommunications technology

Telehealth Services for Chiropractors and Therapists (PT, OT, SLP)

This policy is limited to the following CPT codes®. The codes available to bill as telehealth services are categorized by professional discipline. The inclusion of a code in this section does not guarantee that it will be reimbursed. For further information about reimbursement guidance, please refer to the member's specific health plan coverage documents.

CPT Code®	Description
Chiropractic	
99202	Office/outpatient visit new patient
99203	Office/outpatient visit new patient
99204	Office/outpatient visit new patient
99205	Office/outpatient visit new patient
99212	Office/outpatient visit established patient
99213	Office/outpatient visit established patient
99214	Office/outpatient visit established patient
99215	Office/outpatient visit established patient
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter



OPTUM

97761	Prosthetic training 1st encounter
Physical Therapy	
97161	Physical therapy evaluation – low complexity
97162	Physical therapy evaluation – moderate complexity
97163	Physical therapy evaluation – high complexity
97164	Physical therapy re-evaluation
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter
Occupational Therapy	
97165	Occupational therapy evaluation – low complexity
97166	Occupational therapy evaluation – moderate complexity
97167	Occupational therapy evaluation – high complexity
97168	Occupational therapy re-evaluation
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter
Speech-Language Therapy	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder
92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
96105	Assessment of Aphasia and Cognitive Performance Testing
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97116	Gait training therapy
97129	Therapeutic interventions that focus on cognitive function
97130	Each additional 15 minutes (use in conjunction with 97129)
97530	Therapeutic activities, one-to-one patient contact, each 15 minutes
97535	Self-care management training
97750	Physical performance test
97755	Assistive technology assessment
97760	Orthotic management and training 1st encounter
97761	Prosthetic training 1st encounter

coding matters!

tracking incidence

accurate medical records

research

ICD-10

insurance coverage to test

disability claims

insurance coverage to treat

because your dura maters®

ICD·10·CM
The Official International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2017
PMIC

ICD·10·CM
Home Health & Hospice
The Official International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2018
PMIC

ICD·10·CM
The Official International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2021
PMIC

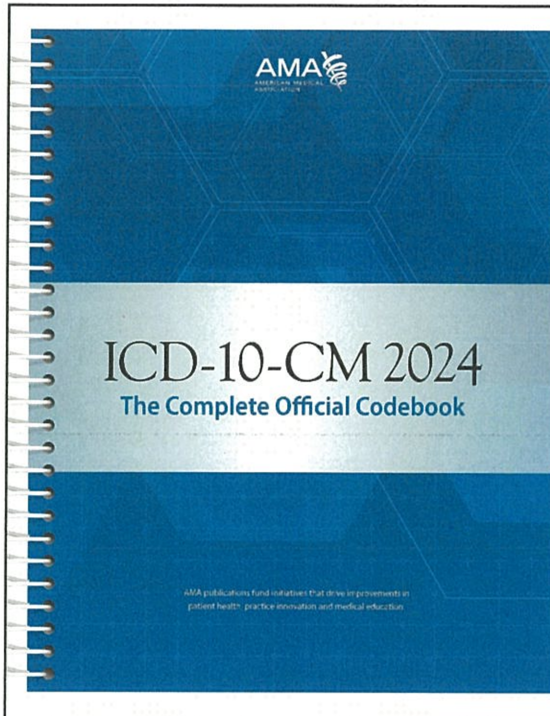
ICD·10·CM
International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2023
PMIC

ICD·10·CM
The Official International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2019
PMIC

ICD·10·CM
The Official International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2020
PMIC

ICD·10·CM
International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2022
PMIC

ICD·10·CM
International Classification of Diseases 10th Revision
Clinical Modification
Color Coded
2024
PMIC



- **2024 update 10-1-2023**
- 73,674 Codes
- 395 Additions
- 25 Deletions
- 13 Revisions

Migraine

- **Added**
- G43.E01 Chronic migraine with aura, not intractable, with status migrainosus
- G43.E09 Chronic migraine with aura, not intractable, without status migrainosus
- G43.E11 Chronic migraine with aura, intractable, with status migrainosus
- G43.E19 Chronic migraine with aura, intractable, without status migrainosus

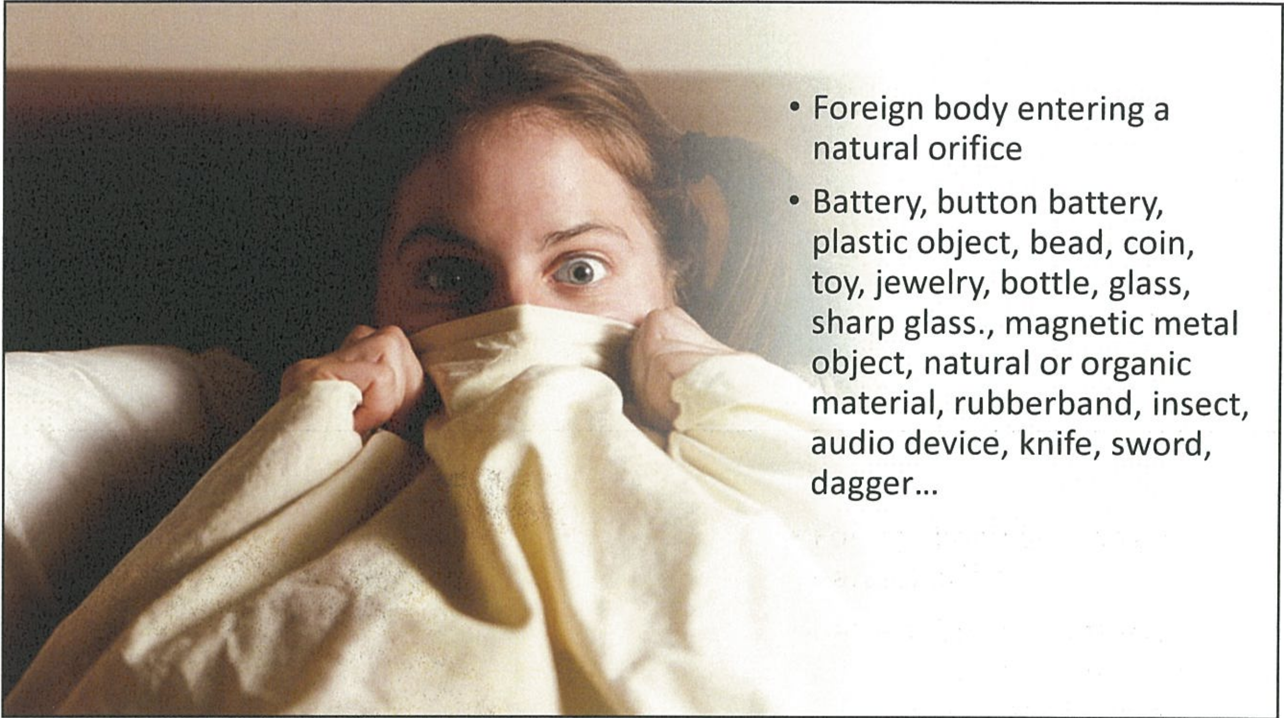
Parkinson's

- **Deleted:**
- G20 Parkinson's disease

- **Added:**
- G20A1 Parkinson's disease without dyskinesia, without mention of fluctuations
- G20A2 Parkinson's disease without dyskinesia, with fluctuations
- G20B1 Parkinson's disease with dyskinesia, without mention of fluctuations
- G20B2 Parkinson's disease with dyskinesia, with fluctuations
- G20C Parkinsonism, unspecified

Osteoporosis

- **Added**
- Pelvic, Age-related osteoporosis or other related osteoporosis with current pathological fracture
- 22 choices


• Foreign body entering a natural orifice
• Battery, button battery, plastic object, bead, coin, toy, jewelry, bottle, glass, sharp glass., magnetic metal object, natural or organic material, rubberband, insect, audio device, knife, sword, dagger…

Head and Spine (Axial Skeleton)

	Headaches
R51.0	Orthostatic headache
R51.9	Headache, unspecified
G44.86	Cervicogenic, Headache
G44.209	Tension-type headache, unspecified, not intractable
G44.219	Episodic tension-type headache, not intractable
G44.229	Chronic tension-type headache, not intractable
G43.009	Migraine without aura, not intractable, without status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43..E01	Chronic migraine with aura, not intractable, with status migrainosus (new code effective 10-1-2023)
G43.E09	Chronic migraine with aura, not intractable, without status migrainosus (new code effective 10-1-2023)
G43..E11	Chronic migraine with aura, intractable, with status migrainosus (new code effective 10-1-2023)
G43.E19	Chronic migraine with aura, intractable, without status migrainosus (new code effective 10-1-2023)
G44.89	Other headache syndrome
	Traumatic Headache
G44.309	Post-traumatic headache, unspecified, not intractable
G44.319	Acute post-traumatic headache, not intractable
G44.329	Chronic post-traumatic headache, not intractable
	Concussion
S06.0X0A	Concussion without loss of consciousness, initial encounter
S06.0XAA	Concussion with loss of consciousness status unknown, initial encounter
F07.81	Post concussion syndrome (postconucssional syndrome)
	TMJ
M26.601	Right temporomandibular (TMJ) joint disorder, unspecified
M26.602	Left temporomandibular (TMJ) joint disorder, unspecified
M26.603	Bilateral temporomandibular (TMJ) joint disorder, unspecified
S03.41XA	Sprain of jaw, right side, initial encounter
S03.42XA	Sprain of jaw,left side, initial encounter
S03.43XA	Sprain of jaw, bilateral , initial encounter
M79.11	Myalgia, muscle of mastication

Cervical Spine

	Subluxation
M99.00	Segmental somatic dysfunction head region
M99.01	Segmental somatic dysfunction cervical region
M99.10	Subluxation complex (vertebral) of head region
M99.11	Subluxation complex (vertebral) of cervical region

	Pain
M54.2	Cervicalgia
M25.50	Pain in joint unspecified (specify cervical spine)
M53.81	Other specified dorsopathies, occipito-atlanto-axial region (syndromes)
M53.82	Other specified dorsopathies, cervical region (syndromes)
M53.83	Other specified dorsopathies, cervicothoracic region (syndromes)
	Nerve
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M54.11	Radiculopathy occipito-atlanto-axial region
M54.12	Radiculopathy cervical region
M54.13	Radiculopathy cervicothoracic region
G54.0	Brachial plexus disorders (thoracic outlet syndrome)
G54.2	Cervical root disorders, not elsewhere classified
S14.2XXA	Injury of nerve root of cervical spine, initial encounter
S14.3XXA	Injury of brachial plexus, initial encounter
	Muscle Tendon
M46.01	Spinal enthesopathy occipito-atlanto-axial region
M46.02	Spinal enthesopathy cervical region
M46.03	Spinal enthesopathy cervicothoracic region
M79.12	Myalgia of auxiliary muscles, head and neck
	Sprain and Strain
S13.4XXA	**Sprain** of ligaments of cervical spine initial encounter
S16.1XXA	**Strain** of muscle, fascia and tendon at neck level initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
	Spondylosis Arthritis
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
	Spondylolisthesis, Deforming Dorsopathies, Curvature, Torticollis
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M40.03	Postural kyphosis cervicothoracic
M40.12	Other secondary kyphosis cervical
M40.13	Other secondary kyphosis cervicothoracic
M43.8X1	Other specified deforming dorsopathies occipitoatlantoaxial
M43.8X2	Other specified deforming dorsopathies cervical
M43.8X3	Other specified deforming dorsopathies cervicothoracic
M43.6	Torticollis
G24.3	Spasmodic torticollis
	Disc
M50.10	Cervical disc disorder with radiculopathy unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy high cervical (C2-3 C3-4)
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy

M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.20	Cervical disc displacement unspecified cervical region
M50.21	Cervical disc displacement C2-3, C3-4 region
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Cervical disc displacement C7-T1 region
M50.30	Cervical disc degeneration, unspecified cervical region
M50.31	Cervical disc degeneration high cervical C2-3 C3-4
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Cervical disc degeneration cervicothoracic region C7-T1
M50.80	Other cervical disc disorders unspecified cervical region
M50.81	Other cervical disc disorders, high cervical region (C2-3 C3-4)
M50.820	Other cervical disc disorders, mid-cervical region, unspecified level
M50.821	Other cervical disc disorders at C4-C5 level
M50.822	Other cervical disc disorders at C5-C6 level
M50.823	Other cervical disc disorders at C6-C7 level
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified cervical region
M50.91	Cervical disc disorder, unspecified high cervical (C2-3 C3-4)
M50.920	Unspecified cervical disc disorder, mid-cervical, unspecified level
M50.921	Unspecified cervical disc disorder at C4-C5 level
M50.922	Unspecified cervical disc disorder at C5-C6 level
M50.923	Unspecified cervical disc disorder at C6-C7 level
M50.93	Unspecified cervical disc disorder cervicothoracic region
	Thoracic Spine
	Subluxation
M99.02	Segmental somatic dysfunction thoracic region
M99.12	Subluxation complex (vertebral) of thoracic region
M89.08	Segmental somatic dysfunction of rib cage
	Pain
M54.6	Pain in thoracic spine
M25.50	Pain in joint unspecified (specify thoracic spine)
M53.84	Other specified dorsopathies, thoracic region
M53.85	Other specified dorsopathies, thoracolumbar region
	Nerve
M54.14	Radiculopathy thoracic (neuritis)
M54.15	Radiculopathy thoracolumbar
G54.0	Brachial plexus lesions (thoracic outlet syndrome)
G54.3	Thoracic root disorders, not elsewhere classified
G58.0	Intercostal Neuropathy
S24.2XXA	Injury of nerve root of thoracic spine, initial encounter

	Muscle Tendon
M46.04	Spinal enthesopathy thoracic region
M46.05	Spinal enthesopathy thoracolumbar region
M79.18	Myalgia, other site
	Sprain and Strain
S23.3XXA	Sprain of ligaments of thoracic spine initial encounter
S29.012A	Strain of muscle and tendon of back wall of thorax initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
	Spondylosis Arthritis
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
	Spondylolisthesis & Deforming Dorsopathies
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.8X4	Other specified deforming dorsopathies thoracic
M43.8X5	Other specified deforming dorsopathies thoracolumbar
	Scolioisis
M41.23	Scoliosis idiopathic, cervicothoracic
M41.24	Scoliosis idiopathic, thoracic
M41.25	Scoliosis idiopathic, thoracolumbar
M41.30	Thoracogenic scoliosis, unspecified
M41.34	Thoracogenic scoliosis, thoracic region
M41.35	Thoracogenic scoliosis, thoracolumbar
	Disc
M51.04	Intervertebral disc disorders with myelopathy, thoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.24	Thoracic intervertebral disc displacement
M51.25	Thoracolumbar intervertebral disc displacement
M51.34	Thoracic or thoracolumbar disc degeneration
M51.35	Thoracolumbar intervertebral disc degeneration
M51.44	Schmorl's nodes thoracic region
M51.84	Other intervertebral disc disorders, thoracic region

Lumbosacral Spine

	Subluxation
M99.03	Segmental and somatic dysfunction, lumbar region
M99.04	Segmental and somatic dysfunction, sacral , sacrococcygeal, sacroiliac regions
M99.05	Segmental and somatic dysfunction, hip, pelvis, pubic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region
	Pain
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M25.50	Pain in joint unspecified (specify lumbar or LS spine)
M53.3	Sacrococcygeal disorders, not elsewhere classified

M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral & sacrococcygeal region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region Disorder of sacrum)
	Nerve
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacrococcygeal region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
G54.1	Lumbosacral plexus disorders
G54.4	Lumbosacral root disorders, not elsewhere classified
G57.01	Lesion of sciatic nerve, right lower limb (piriformis syndrome)
G57.02	Lesion of sciatic nerve, left lower limb (piriformis syndrome)
G57.03	Lesion of sciatic nerve, bilateral lower limb (piriformis syndrome)
S34.21XA	Injury of nerve root of lumbar spine, initial encounter
S34.22XA	Injury of nerve root of sacral spine, initial encounter
S34.4XXA	Injury of lumbosacral plexus, initial encounter
S74.01XA	Injury of sciatic nerve at hip and thigh level, right leg, initial encounter
S74.02XA	Injury of sciatic nerve at hip and thigh level, left leg, initial encounter
	Muscle Tendon
M46.06	Spinal enthesopathy lumbar region
M46.07	Spinal enthesopathy lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M79.18	Myalgia, other site
	Sprain and Strain
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.9XXA	Sprain of unspecified parts of lumbar spine and pelvis, initial encounter
	Spondylosis Arthritis
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
	Spondylolisthesis
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.8X6	Other specified deforming dorsopathies lumbar
M43.8X7	Other specified deforming dorsopathies lumbosacral
M43.8X8	Other specified deforming dorsopathies sacral and sacrococcygel

	Scolioisis
M41.26	Scoliosis idiopathic,lumbar
M41.27	Scoliosis idiopathic, lumbosacral
	Disc
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Intervertebral disc displacement, lumbar region
M51.27	Intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.45	Schmorl's Nodes thoracolumbar region
M51.46	Schmorl's Nodes lumbar region
M51.47	Schmorl's Nodes lumbosacral region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M51.9	Unspecified thoracic, TL and LS intervertebral disc disorder
M51.A0	Intervertebral annulus fibrosus defect, lumbar region, unspecified size
M51.A1	Intervertebral annulus fibrosus defect, small, lumbar region
M51.A2	Intervertebral annulus fibrosus defect, large, lumbar region
M51.A3	Intervertebral annulus fibrosus defect, lumbosacral region, unspecified size
M51.A4	Intervertebral annulus fibrosus defect, small, lumbosacral region
M51.A5	Intervertebral annulus fibrosus defect, large, lumbosacral region
	Miscellaneous Spine and Spine Related
	Muscle
M79.10	Myalgia, unspecified site
M79.11	Myalgia of muscles of mastication
M79.12	Myalgia of auxiliary muscles, head and neck
M79.18	Myalgia, other site
M79.2	Neuralgia and neuritis, unspecified
M79.7	Fibromyalgia
M62.81	Muscle weakness
M62.5A0	Muscle wasting and atrophy, not elsewhere classified, back, cervical
M62.5A1	Muscle wasting and atrophy, not elsewhere classified, back, thoracic
M62.5A2	Muscle wasting and atrophy, not elsewhere classified, back, lumbosacral
M62.5A9	Muscle wasting and atrophy, not elsewhere classified, back, unspecified level
M60.88	Other myositis, other site
M62.830	Muscle spasm of back
M62.838	Other muscle spasm
M24.50	Contracture, unspecified joint
M72.9	Fibroblastic disorder, unspecified
	Stiffness, Pain, Nerve
M25.60	Stiffness of unspecified joint, not elsewhere classified (spine)
M25.78	Osteophyte, vertebrae
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.9	Dorsopathy, umspecified

G54.8	Other nerve root and plexus disorders
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
G55	Nerve root and plexus compressions in diseases classified elsewhere
	Spondylisthesis, Malformation, Ligament
M43.19	Spondylolisthesis, multiple sites in spine
Q76.2	Congenital spondylolisthesis
Q76.49	Other congenital malformations of spine, not associated with scoliosis
M24.80	Other specific joint derangements of unspecified joint, not elsewhere classified
M24.9	Joint derangement, unspecified
	Ligament Laxity and Biomechanical Lesions
M24.28	Disorder of ligament, vertebrae (ligament laxity)
M99.80	Other biomechanical lesions, of head region
M99.81	Other biomechanical lesions, of cervical region
M99.82	Other biomechanical lesions, of Thoracic region
M99.83	Other biomechanical lesions, of lumbar region
M99.84	Other biomechanical lesions, of sacral region
M99.84	Other biomechanical lesions, of pelvic region
	Spinal Stenosis
M48.01	Spinal stenosis occipito-atlanto-axial region
M48.02	Spinal stenosis cervical region
M48.03	Spinal stenosis cervicothoracic region
M48.04	Spinal stenosis thoracic region
M48.05	Spinal stenosis thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis lumbosacral region
M48.08	Spinal stenosis sacral and sacrococcygeal region
	Post surgical
M96.1	Postlaminectomy syndrome, not elsewhere classified
Z98.890	Other specified postprocedural states (post surgical pain)
G89.18	Acute post procedural pain
G89.28	Other chronic post procedural pain
	Pregnancy
Z33.1	Pregnant state, incidental
M54.59	Other low back pain
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
O99.89	Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium (low back pain pregnancy)
	Pain
G89.0	Central pain syndrome
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute post procedural pain
G89.21	Chronic pain due to trauma

G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic post procedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome (Chronic pain associated with psychosocial dysfunction)
R52	Pain, unspecified
	Fatigue
G93.31	Postviral fatigue syndrome
R53.1	Weakness (Asthenia NOS)
R53.81	Other malaise (debility, general physical deterioration, malaise NOS, nervous debility)
R53.82	Chronic fatigue, unspecified (chronic fatigue syndrome)
R53.83	Other fatigue (lack of energy, lethargy, tiredness)
R54	Age related physical debility (frailty, old age, senescence, senile asthenia, senile debility)

Code	Type 1 Code Exclusion – These codes cannot be coded together on the same claim
M54.2	- cervicalgia due to intervertebral cervical disc disorder (M50.-)
M54.50, M54.51, or M54.59	- low back strain (S39.012) lumbago due to intervertebral disc displacement (M51.2-) lumbago with sciatica (M54.4-)
M54.6	- pain in thoracic spine due to intervertebral disc disorder (M51.- S23.- S33-)
M54.4-	- lumbago with sciatica due to intervertebral disc disorder (M51.1-) M54.3, M54.5, M79.2
M54.81	- dorsalgia in thoracic region (M54.6) low back pain (M54.5)
M54.89	- dorsalgia in thoracic region (M54.6) low back pain (M54.5x)
M54.1-	- neuralgia and neuritis NOS (M79.2) radiculopathy with cervical disc disorder (M50.1) radiculopathy with lumbar and other intervertebral disc disorder (M51.1) radiculopathy with spondylosis (M47.2) Nerve root and plexus disorders (G50-59)
M50. -	- cervicalgia (M54.2), traumatic rupture of cervical intervertebral disc (S13.0-)
M51.-	- lumbar dislocation and sprain (S33.-), traumatic rupture of lumbar intervertebral disc (S33.0-), thoracic pain (M54.6), dislocation and sprain of thoracic S23.-) M54.- M54.3- and M54.4-
M53.-	nerve root plexus compressions in diseases classified elsewhere (G55.)
S33.-	- nontraumatic rupture or displacement of lumbar intervertebral disc NOS (M51) obstetric damage to pelvic joints and ligaments (O71.6)
S39.012-	low back pain (M54.5)
S23.-	- rupture or displacement (nontraumatic) of thoracic intervertebral disc NOS (M51)
M79.1-	- fibromyalgia (M79.7) myositis (M60.-) disorders of muscles (spasm, cramp) (M62.-)
M79.7	- myalgia (M79.1-)
M62-	- myalgia (M79.1-), cramp spasm (R25.82) stiff man syndrome (G25.82)
M47.-	- nerve root plexus disorders (G54.-)
G54.-	- intervertebral disc disorders (M50, M51), neuralgia or neuritis NOS (M79.2), neuritis or radiculitis brachial NOS (M54.13), neuritis or radiculitis lumbar NOS (M54.16), neuritis or radiculitis lumbosacral NOS (M54.17), neuritis or radiculitis thoracic NOS (M54.14), radiculitis NOS, radiculopathy (M54.10), . spondylosis (M47.-)
G55.-	ankylosing spondylitis (F45.-), dorsopathies (M53.- M54.-)., disc disorders (M50.1- M51.1-), spondylosis (M47.0- M47.2-), spondylopathies M46.-, M48.-)
M40.-	- congenital kyphosis and lordosis (Q76.4), kyphoscoliosis (M41), postprocedural kyphosis and lordosis (M96.)
M41.-	-congenital scoliosis NOS (Q67.5), congenital scoliosis due to bony malformation (Q76.3), postural congenital scoliosis (Q67.5), kyphoscoliotic heart disease (I27.1), postprocedural scoliosis (M96.)
M43.-	-congenital spondylolysis and spondylolisthesis (Q76.2), hemivertebra (Q76.3, Q76.4-), Klippel-Feil syndrome. M43.01 to M43.0x may not be coded with M43.1x (Q76.1), lumbarization and sacralization (Q76.4), spina bifida occulta (Q76.0), spinal curvature in osteoporosis (M80.), spinal curvature in Paget's disease of bone [osteitis deformans] (M88.)
M46.-	-nerve root and plexus compressions in diseases not classified elsewhere (G55.-)